Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL286865783M
Compliance #: HL286869928C

Date Concluded: April 20, 2023

Name, Address, and County of Licensee Investigated:

Hyatt House
231 Washington Street
Holdingford, MN 56340
Stearns County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility abused a resident when they restrained the resident in his room using a baby gate.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The facility was responsible for the maltreatment. One month after the resident was admitted to the facility the resident was found alone outside. The facility determined the resident required one on one staff supervision to ensure the residents safety. The facility was unable to provide one to one staffing for the resident and instead restrained the resident in his room using a baby gate. The facility lacked documentation of physician orders for the restraint, documentation of alternative interventions attempted, and specific unsafe behaviors related to the use of the restraint. The restraint was in place for over eight months.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's county case manager and medical provider. The investigation included review of resident's medical record, medication and treatment administration records, incident reports, after visit summaries, signed provider orders, and facility policies and procedures. In addition, the investigator observed the baby gate restraint in use, and staff provision of cares.

The resident resided in an assisted living facility with diagnoses including developmental delay, non-verbal, blindness, and Diabetes Meletus type II.

The resident's most recent assessment, indicated the resident was developmentally delayed, had a language barrier and was not able to communicate, was legally blind, had poor safety awareness, and was unable to walk without staff assistance and scooted on his bottom on the floor to mobilize. The assessment identified the resident was at risk for elopement, wandered and required frequent redirection.

A facility incident report indicated one month after admission to the facility the resident eloped and was found outside alone. The incident report indicated staff were to provide one to one supervision to the resident to prevent recurrence.

The following day the resident's service plan was updated and indicated if staff were unable to provide one to one supervision, the resident should be in his room with a baby gate up to ensure his safety. The service plan identified the resident wandered with elopement tendencies and indicated staff would provide redirection and supervision when he was out of his room.

Three months later, the resident's signed Physician's Orders indicated the facility requested a physician order for use of a baby gate on the resident's door when staff were unable to be with the resident. The physician wrote, "No to use of safety gate." Although the physician did not provide an order to use the baby gate as a restraint for the resident, the facility continued to restrain the resident using the baby gate.

While onsite the investigator observed the resident in his room lying in bed and a baby gate was across the doorway. The resident made periodic, repetitive vocalizations including moaning and high-pitched sounds until staff responded to the resident.

The residents record indicated staff documented when the baby gate restraint was used. The documentation indicated most days the resident was in his room with the baby gate in place for up to seven hours at a time. The documentation indicated the baby gate restraint was put into place after the evening meal and remained in place all night until the resident went out for breakfast the following day.

When interviewed facility staff stated the resident liked to be around other residents and staff. The staff stated other residents had yelled, swore, kicked at the resident, and threatened to

harm the resident due to the residents' loud vocalizations. If staff were not able to be with the resident, he was in his room with the gate up. Staff stated the resident was unable to remove the baby gate and could not get out of his room with the gate in place. Staff stated the resident had declined recently and was more resistive with cares, refused to walk with staff and scooted on the floor instead, had increased vocalizations, decreased intake, and increased rocking motions. Staff stated the resident did the rocking when he was upset or sad.

One staff member stated the resident does not go towards the baby gate anymore to attempt to get out of his room. The staff stated when the residents' vocalizations got loud, they knew the resident was done "being cooped up" and staff would let him out of his room to "roam a bit".

The facility nursing staff stated the resident was developmentally delayed and had the cognition of a one or a two-year-old. The nurse stated the baby gate was needed if staff were busy and not able to monitor him. The nurse stated she was aware the baby gate was a restraint, and the resident was unable to exit his room with the baby gate in place. The nurse stated they were unable to get a physician order for the restraint, and she was unsure what other interventions were attempted to ensure the residents safety instead of restraining the resident.

When interviewed facility leadership stated they were aware using a baby gate to confine the resident to his room was considered a restraint. Leadership staff stated they tried to get a provider order for the baby gate, however, the provider refused because it restricted the resident's rights. Leadership staff stated they continue to use the baby gate because "safety was more important". Leadership staff stated because of the resident's history of elopement, the resident was restrained in his room with the baby gate if staff were unable to be one on one with the resident. Leadership staff stated the facility had a door sensor that would alarm if the resident opened the door going outside the facility, but it was only turned on when the baby gate was down, and the resident was out of his room. The alarm sounded when anyone came in and out of the door, so it was generally turned off during the day. Leadership indicated they had not implemented any other interventions to ensure the residents safety besides restraining the resident in his room using the baby gate.

The resident's family member stated after the resident was found outside the facility alone, the facility put a baby gate up to keep the resident in his room until they figured out what else they could do to keep the resident safe. The family member stated the resident has been restrained in his room for approximate eight months and was not aware if the facility had tried to do anything else to ensure the resident was safe. The family member stated on several occasions when visiting the facility, staff were observed sitting at the desk and the resident was restrained in his room with the baby gate in place. The family member stated the resident had lost weight and appeared more thin than usual.

The resident record lacked clear and consistent documentation of the residents functional, behavioral, or health status. The facility had no documentation of the resident's weights, and

lacked documentation regarding meal intake, specific unsafe behaviors, and interventions attempted prior to using the restraint.

In conclusion, abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825

Vulnerable Adult interviewed: No - unable
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4890 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Sterns County Attorney
Holdingford City Attorney
Holdingford Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28686	A. BUILDING: _____ B. WING _____	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYATT HOUSE LLC	231 WASHINGTON STREET HOLDINGFORD, MN 56340

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0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL286865783M,/#HL286869928C On April 6, 2023, the Minnesota Department of Health conducted an investigation at the above provider, and the following correction orders are issued. At the time of the investigation, there were 13 residents receiving services under the provider's Assisted Living license. The following correction order was issued for HL286865783M, and HL286869928C, tag identification 0450, 0470, 1640, 2310, and 2360.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 450 SS=G	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of	0 450		

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0 450	Continued From page 1 rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure person-centered planning and appropriate dignified service delivery process for one of one resident (R1). R1 had a decline in function and was psychosocially harmed when the facility utilized a baby gate restraint to confine R1 to his room alone. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on July 18, 2022, with diagnoses including developmental delay, non-verbal, blindness, and Diabetes Mellitus.	0 450		

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0 450	Continued From page 2 A facility incident report dated August 17, 2022, one month following admission, indicated the resident eloped from the facility and was found outside alone. The incident report indicated staff were to provide one to one supervision to prevent recurrence. On August 18, 2022, the following day, R1's service agreement was updated and indicated if staff were unable to provide one to one supervision the resident was to be in his room with a baby gate up to ensure his safety. R1's service plan dated March 30, 2023, identified the resident wandered with elopement tendencies and indicated staff would provide redirection and supervision when he was out of his room. The service plan indicated if staff were unable to provide one to one supervision the resident was to be in his room with a baby gate up to ensure his safety, which was initiated on August 18, 2022, the day after R1 eloped from the facility R1's signed "Physician's Orders Sheet dated November 11, 2022, indicated the facility requested an order for use of a baby gate blocking the residents exit from his room for safety when staff were unable to be with him. The signed orders indicated under the new orders section, order #2 the provider wrote "No to use of safety gate". On March 10, 2023, at 1:43 p.m. an email communication from R1's county case manager (CCM)-F to the facility licensed assisted living director (LALD)-C indicated CCM-F inquired if a baby gate was being used for R1. On March 13, 2023, at 12:50 p.m. an email	0 450		

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0 450	Continued From page 3 communication from LALD-C to CCM-F indicated LALD-C responded that R1 was essentially a one-year-old and required constant supervision. LALD-C indicated the facility did not have staff to be with R1 one to one, so the baby gate was used to keep him safe. On March 14, 2023, at 11:56 a.m. an email communication from LALD-C to CCM-F indicated R1 moved around and got into lots of things. LALD-C indicated the facility was not locked and R1 liked to go towards the door. On March 14, 2023, at 12:50 p.m. an email communication from CCM-F to LALD-C indicated CCM-F inquired how often R1 was in his room with the baby gate and expressed the family had concern it was causing R1 a lot of sadness. On March 14, 2023, at 1:16 p.m. an email communication from LALD-C to CCM-F indicated R1 was out of his room for all meals, and when staff had time to monitor him, which was mostly in the evening. On March 14, 2023, at 4:16 p.m. an email communication from CCM-F indicated she reviewed documentation of the facilities having a door alarm in case R1 tried to leave the facility without assistance. CCM-F expressed concern of isolation for R1 because he could not leave his room. LALD-C did not respond. On March 22, at 9:40 a.m. a follow up email communication from CCM-F to LALD-C indicated CCM-F expressed concern R1 was being locked in his room and wanted to work with the facility to remove the baby gate. On March 27, at 11:44 a.m. an email	0 450		

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0 450	Continued From page 4 communication from LALD-C to CCM-F indicated R1 was out of his room regularly, and R1 could see everyone as they walk by. On March 27, at 1:10 p.m. an email communication from CCM-F to LALD-C indicated CCM-F expressed she understood the primary concern was R1 leaving his room without staff oversight, as he may try to leave the facility. CCM-F provided an amazon link for a door alarm system the facility could implement to remove the baby gate. LALD-C failed to respond. On April 7, 2023, CCM-F sent a follow up email to LALD-C with no response as of April 10, 2023. Facility documentation for when the baby gate was in use included documentation from January 14, 2022, to April 10, 2023. The document included date, time, resident location, and a yes or no section for if the gate was in use. The document indicated most of the day the resident was in his room with the baby gate in place, at times for up to seven hours at a time during the day unless the resident was out for meals. The documentation indicated the baby gate was put into place after the evening meal and remained in place during the night until the resident went out for breakfast the following day. Facility documentation for safety concerns from November 16, 2022, to April 10, 2023, included a list of things R1 had grabbed or touched. The document indicated R1 had gone towards the exit doors or tried to go outside. However, R1's record lacked documentation of incidents of elopement or elopement attempts since August 17, 2022. The documentation lacked any interventions implemented, redirection provided, effectiveness, or other actions taken to keep R1 safe other than	0 450		

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0 450	Continued From page 5 the use of the baby gate restraint. During continuous observations on April 6, 2023, at 10:20 a.m., a baby gate was observed in the doorway of R1's room preventing the resident from leaving his room. At 11:07 a.m. R1 was heard moaning in his room with intermittent loud high-pitched vocalizations. Unknown staff were observed walking by R1's room periodically, however, did not engage the resident face to face. On April 6, 2023, at 11:30 a.m. unlicensed personal (ULP)-D stated R1 liked to be around staff and other residents. ULP-D stated if the resident was in his room the baby gate was up because when R1 screamed other residents had kicked him. ULP-D stated R1 doesn't go near the baby gate anymore, and if R1's vocalizations got loud they knew he was "done being cooped up" and "staff let him out of his room to roam a bit". On April 6, 2023, at 10:30 a.m. ULP- A stated the facility used a baby gate to keep R1 safe because other resident's yell, swore, and kicked at R1 when he was crawling around on the floor making loud noises. ULP-A stated R1 could not remove the baby gate to get out of his room. ULP-A indicated the baby gate was down when R1 was out for meals or if they had time to watch him. ULP-A indicate the gait was in place during the night because R1 could open his door and come out of his room. On April 6, 2023, at 12:25 p.m. during follow up interview, ULP-D stated they only have two staff on per shift and could not keep an eye on R1 all the time. ULP-D stated the baby gate was implemented after R1 got outside. ULP-D stated R1 used to walk with assistance everywhere, but	0 450		

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0 450	Continued From page 6 in the last two to three months R1's behaviors were "way worse", and described R1 had more hollering, increased loud high-pitched vocalizations, was more resistive with cares, refused to walk, refused his wheelchair, and scooted on the floor everywhere now instead of walking with staff. ULP-D stated R1 had been kicked and swore at by other resident's while on the floor. On April 6, 2023, at 1:48 p.m. registered nurse (RN)-B stated R1 was developmentally delayed, non-verbal, non-ambulatory without staff assistance, and scooted on his bottom using his hands and feet. RN-B indicated R1 had the cognition of a one- to two-year-old child, and staff used the baby gate to confine him in his room for safety. RN-B stated the baby gate was down for meals a few hours a day. RN-B stated R1 was unable to remove the baby gate, and it was a restraint. RN-B stated there was no signed physician order for use of a restraint, nor was there a plan for staff to follow or monitor the use of the restraint. RN-B indicated she was unaware of other interventions tried besides the baby gate to keep R1 safe. On April 6, 2023, at 2:45 p.m. ULP-E stated staff used the baby gate when they could not be with R1, and it was in place up to six hours during a seven hour evening shift. ULP-E stated in the past couple months R1 had declined, was stubborn and resistive with cares including toileting, refused to stand, walk, and wanted to scoot everywhere on his bottom. ULP-E stated R1 has had a decreased intake at mealtimes, and had more rocking behaviors which was something R1 did when he was sad or upset. On April 10, 2023, at 4:32 p.m. LALD-C stated R1	0 450		

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0 450	Continued From page 7 liked to be around others but required constant supervision because he was always into things such as reached to touch a fan, touched outlets, put things in his mouth, and went toward the facility exit. LALD-C stated R1 needed one to one supervision, but they did not have enough staff, so the baby gate was implemented to keep R1 safe. LALD-C stated there was an alarm system on the facility exit doors that chimed when anyone entered or exited the facility, but it was turned off unless R1 was out of his room. LALD-C stated she was aware the baby gate was a restraint and tried to get a doctor's order, but R1's provider refused, and told them it would restrict R1's rights. LALD-C stated R1's safety was more important, and the facility continued to use the baby gate without a physician order. LALD-C stated since R1 eloped from the facility they had not implemented any other interventions to keep R1 safe other than use the baby gate. LALD-C stated she was unaware of any other options to keep R1 safe to remove the baby gate, despite being provided information for an alternative alarm system from CCM-F. A facility policy and procedure titled "Service Plan" dated December 1, 2016, indicated an individualized service plan was implemented for all residents based on assessed needs. No further information was provided. TIME PERIOD FOR CORRECTION: Two Days (2) days.	0 450		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 8 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to meet the needs of all residents when one of one resident (R1) was restrained in his room for prolonged periods of time due to lack of staffing. This had the potential to affect all residents who resided in the facility and staff. This practice resulted in a level two violation (a violation that did not harm a client's health or	0 470		

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	28686	A. BUILDING: _____ B. WING _____	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYATT HOUSE LLC	231 WASHINGTON STREET HOLDINGFORD, MN 56340

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0 470	Continued From page 9 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the facility on July 18, 2022, with diagnoses including developmental delay, non-verbal, blindness, and Diabetes Mellitus. An incident report dated August 17, 2022, one month after admission to the facility,indicated R1 eloped from the facility and was found outside alone. The incident report indicated staff were to provide one to one supervision to prevent recurrence. R1's service plan dated March 30, 2023, identified the resident wandered with elopement tendencies and indicated staff would provide redirection and supervision when he was out of his room. The plan indicated if staff were unable to provide one to one supervision the resident was to be in his room with a baby gate up to ensure his safety, initiated on August 18, 2022, the day after R1 eloped from the facility. On November 11, 2022, R1's signed "Physician's Orders Sheet" indicated the facility requested an order for use of a baby gate on the resident's door for safety when staff were unable to be with him. The signed orders indicated, "No to use of safety gate". Facility documentation for the baby gate use from January 14, 2022, to April 10, 2023, included	0 470		

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0 470	Continued From page 10 date, time, resident location, and a yes or no section for if the gate was in use. The document indicated in general the resident was in his room with the baby gate in place during the day for up to seven hours at a time, unless the resident was out for meals. The documentation indicated the baby gate was put into place after the evening meal and remained in place during the night until the resident went out for breakfast the following day. On April 6, 2023, at 12:25 p.m. unlicensed personnel (ULP)-D stated they only have two staff on per shift and could not keep an eye on R1 all the time, so they used the baby gate to keep R1 safe. On April 6, 2023, at 1:48 p.m. registered nurse (RN)-B stated staffing was an issue, and staff used a baby gate to confine R1 to his room for his safety when staff were unable to be with R1. RN-B stated the baby gate was down for meals a few hours a day. On April 6, 2023, at 2:45 p.m. ULP-E stated staff used the baby gate when they could not be with R1, up to six hours during a seven-hour evening shift. On April 10, 2023, at 4:32 p.m. the facility licensed assisted living director (LALD)-C stated R1 required constant one to one staff supervision. LALD-C stated they did not have enough staff to supervise R1, so they used a baby gate to keep R1 safe. The facility staffing plan was requested and not provided. The facility policy and procedure titled "Staffing,	0 470		

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0 470	Continued From page 11 Direct Care Staffing Plan, and Daily Schedule" dated August 1, 2021, indicated one or more persons would be available 24 hours per day seven days per week who are to respond to residents' health and safety needs. The staffing plan would provide sufficient staff to meet the needs of the resident's 24 hours a day. Each resident's needs were identified in the service plan, and acuity of the resident was based on the resident's most recent assessment. The policy indicated the staffing plan would be reviewed and revised a minimum of two times per year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 470		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record,	01640		

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01640	Continued From page 12 including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a service plan was implemented and services provided were documented accurately for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include R1 was admitted to the facility on July 18, 2022, with diagnoses including developmental delay, non-verbal, blindness, and Diabetes Mellitus. R1's 90-day assessment dated March 30, 2023, indicated R1 was visually impaired and legally blind, memory impaired, had poor safety awareness, language barriers, developmental delay, and had exit seeking behavior. The assessment indicated R1 had a behavior management plan that would be evaluated by the nurse monthly. R1's physicians orders signed on November 11, 2022, included orders for R1 to have monthly	01640		

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01640	Continued From page 13 weights completed on the 18th of every month, initiated on admission. R1's service plan dated March 30, 2023, indicated R1 would have face to face safety checks every 15 minutes each shift to address his needs and ensure safety. The plan indicated staff would walk R1 to all meals for optimal independence with ambulation. The plan indicated staff would document R1's meal intake and complete monthly weight monitoring. On April 6, 2023, at 10:20 a.m. a baby gate was observed in the doorway of R1's room, while R1 was in bed. During continuous observation from 10:40 a.m. R1 was heard moaning in his room with intermittent loud high-pitched vocalizations at 11:07 a.m. Unknown staff were observed walking by R1's room periodically, however, did not engage R1 face to face until unlicensed personnel (ULP)-D entered R1's room at 11:23 a.m. On April 6, 2023, at 11:30 a.m. ULP-D stated in the past few months R1 had declined, was more resistive with cares, and had more episodes of high-pitched yelling. ULP-D stated R1 used to be able to walk with staff assistance everywhere, but now R1 refused to walk and wanted to scoot on his bottom on the floor instead. On April 6, 2023, at 1:48 p.m. registered nurse (RN)-B stated R1 was developmentally delayed, non-verbal, required staff assistance to ambulate, and scooted on his bottom using his hands and feet to mobilize. RN-B indicated she was not aware of changes in R1's behavior and mood. On April 6, 2023, at 2:45 p.m. ULP-E stated in the past few months R1 had become more resistive	01640		

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01640	Continued From page 14 with cares, toileting, refused to stand, refused to walk and scooted on his bottom instead, and had decreased intake. On April 10, at 11:18 a.m. R1's family member stated R1 had lost weight and was now "skin and bones." R1's Service Delivery Record from March 1, 2023, to April 9, 2023, included documentation of services provided each shift. The record indicated 15-minute checks had not consistently been done, and eight shifts had not completed the checks. The record failed to indicate which shift had not completed the checks. The service record failed to indicate R1 walked to meals, and only had documentation for ambulation three times daily. The record indicated staff ambulated R1 every day in March and April 2023. R1's record lacked any documentation of weight monitoring ever being completed since admission, and R1's intake documentation lacked consistent, clear, accurate documentation to determine if R1 had decreased intake or weight loss. On April 10, 2023, at 4:32 p.m. LALD-C stated R1 had been more stubborn lately and refused to walk. LALD-C stated they had no record of R1's weights being done since admission, because they did not have a scale R1 could use. LALD-C indicated R1's weights were done at the clinic but the facility had no record of them. R1's behavior management plan, and reviews were requested, none were provided. A facility policy and procedure titled "Service Plan" dated December 1, 2016, indicated an	01640		

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01640	Continued From page 15 individualized service plan was implemented for all residents based on resident assessed needs. A policy titled "Resident Records" dated August 1, 2021, indicated staff would document health information and services provided in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	01640		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide appropriate care and services to ensure dignified and appropriate safety interventions were implemented for one of one resident's (R1) when the licensee used a baby gate to restraint R1 in his room for prolong periods of time. R1 had a decline in function and was psychosocially harmed. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was	02310		

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02310	Continued From page 16 issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's community support plan dated July 7, 2022, 11 days prior to facility admission, indicated R1 was a social person who was most happy when he could be around others. The assessment indicated R1 should be encouraged to walk daily to improve strength and endurance. The assessment indicated a goal was to have R1 live where he could have increased social interactions. R1 was admitted to the facility on July 18, 2022, with diagnoses including developmental delay, non-verbal, blindness, and Diabetes Mellitus. R1's facility 90-day assessment dated March 30, 2023, indicated R1 was visually impaired and legally blind, memory impaired, had poor safety awareness, language barriers, developmental delay, and had exit seeking behavior. The assessment indicated R1 had a behavior management plan that would be evaluated by the nurse monthly. R1's behavior management plan, and reviews were requested, none were provided. An incident report dated August 17, 2022, one month after admission to the facility, indicated the resident eloped from the facility and was found outside alone. The incident report indicated staff were to provide one to one supervision to prevent recurrence.	02310		

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02310	Continued From page 17 On November 11, 2022, R1's signed "Physician's Orders Sheet" indicated the facility requested an order for use of a baby gate on the resident's door to prevent the resident from exiting when staff were unable to be with R1. The signed orders indicated the physician documented, "No to use of safety gate". In addition, the orders included weight monitoring to be completed by the facility each month, which had been initiated on admission. R1's service plan dated March 30, 2023, identified R1 wandered with elopement tendencies and indicated staff would provide redirection and supervision when he was out of his room. The plan indicated if staff were unable to provide one to one supervision R1 should be in his room with a baby gate up to ensure his safety. The baby gate was documented as initiated on August 18, 2022, the day after R1 eloped from the facility. The plan indicated R1 would have face to face safety checks every 15 minutes to address his needs and ensure safety. The plan indicated staff would walk R1 to all meals and would provide assistance and support for optimal independence with ambulation. The service plan included meal intake and monthly weight monitoring. R1's Service Delivery Record from March 1, 2023, to April 9, 2023, included documentation of services provided each shift. The record indicated 15-minute checks had not consistently been done, and eight shifts had not completed the checks. The record failed to indicate which shift had not completed the checks. The service record failed to indicate R1 walked to meals, and only had documentation for ambulation three times daily. The record indicated staff ambulated R1 every day in March and April 2023.	02310		

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02310	Continued From page 18 R1's record lacked any documentation of weight monitoring ever being completed since admission. R1's documentation of intake lacked consistent, clear, accurate documentation to determine if R1 had decreased intake or weight loss. On November 30, 2022, at 2:25 p.m. R1's progress note indicated R1 had been out of his room all day, went in and out of the dining room, and looked out the front door. The note indicated R1 was doing very well and expressed no safety concern. On December 2, 2022, at 1:17 p.m. R1's progress note indicated R1 had been out of his room all day and done very well again. The note indicated R1 goes to the front door and sits to look out the door. The note indicated R1 enjoyed going into the dining room to watch staff work in the kitchen. On December 6, 2022, at 1:20 p.m. R1's progress note indicated R1 had been out of his room all day, with no safety concerns. On December 12, 2022, at 10:15 p.m. R1's progress note indicated R1 had done great being out of his room all day, went up and down the main hallway into the dining room. On December 13, 2022, at 1:09 p.m. R1's progress note indicated R1 was out and about in the facility and had done well. The note indicated R1 went to the facility doors and looked outside, went into the dining room, then sat in his chair. R1's progress notes from December 14, 2022, to April 6, 2023, had no documentation of R1 being out of his room with the baby gate down.	02310		

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02310	Continued From page 19 Facility documentation for the baby gate use included documentation from January 14, 2022, to April 10, 2023. The document included date, time, resident location, and a yes or no section for if the gate was in use. The document indicated most days the resident was in his room with the baby gate in place for up to seven hours at a time unless the resident was out for meals. The documentation indicated the baby gate was put into place after the evening meal and remained in place during the night until the resident went out for breakfast the following day. Facility documentation regarding safety concerns for R1 from November 16, 2022, to April 10, 2023, included a list of things R1 had grabbed or touched when not restrained by the baby gate; such as pulling papers off a table or eating paper. The document indicated R1 had gone towards the exit doors and tried to go outside. R1's record lacked documentation of incidents of elopement or elopement attempts since August 17, 2022, and lacked documentation of interventions implemented, redirection provided, effectiveness, or other actions taken to keep R1 safe other than the use of the baby gate restraint. On March 27, at 1:10 p.m. an email communication from R1's county case manager (CCM)-F to the licensed assisted living director (LALD)-C indicated concerns regarding the baby gate use. In the email CCM-F indicated she understood the primary concern was R1 leaving his room without staff oversight, as he may try to leave the facility. CCM-F provided an amazon link for a door alarm system the facility could implement to remove the baby gate. As of April 10, 2023, LALD-C had failed to respond.	02310		

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02310	Continued From page 20 On April 6, 2023, at 10:20 a.m. R1 was observed in bed and a baby gate was across the doorway of R1's room. During continuous observation beginning at 10:40 a.m. R1 was heard moaning in his room with intermittent loud high-pitched vocalizations at 11:07 a.m. Unknown staff were observed walking by R1's room periodically, however, did not engage R1 face to face until unlicensed personnel (ULP)-D entered R1's room at 11:23 a.m. and assisted R1 with toileting and incontinence care. - At 11:45 a.m. ULP-D left R1's room and R1 was seated on the edge of the bed and the baby gate down. R1 lowered himself to the floor using his arms on the edge of the bed, then scooted on his bottom using his hands and feet to propel himself out of his room into the dining room and pulled himself into a chair for lunch. On April 6, 2023, at 10:30 a.m. ULP- A stated the facility used a baby gate to keep R1 safe because other residents had yelled, swore at, and kicked at R1 when he was crawling around on the floor. ULP-A stated R1 could not remove the baby gate, and the gate was taken down when R1 was out for meals. ULP-A indicate the gait was in place during the night because R1 could open his door and come out of his room but he could not remove the baby gait. On April 6, 2023, at 11:30 a.m. ULP-D stated R1 liked to be around staff and other residents. ULP-D stated if the resident was in his room the baby gate was up because other residents had kicked and swore at R1. ULP-D stated R1 doesn't go near the baby gate anymore, and if his vocalizations got loud, they knew he was "done being cooped up" and "staff let him out of his	02310		

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02310	Continued From page 21 room to roam a bit". ULP-D stated in the past few months R1 had declined, was more resistive with cares, and had more episodes of high-pitched yelling. ULP-D stated she used to be able to walk R1 everywhere, however, now R1 refused to walk and scoots on his bottom on the floor. On April 6, 2023, at 1:48 p.m. registered nurse (RN)-B stated R1 was developmentally delayed, non-verbal, required staff assistance to ambulate, and scooted on his bottom using his hands and feet to mobilize. RN-B indicated R1 had the cognition of a one- to two-year-old child, and staff used the baby gate to confine R1 to his room for safety. RN-B stated R1 was unable to remove the baby gate and it was a restraint, however, they did not have enough staff to provide the supervision R1 needed. RN-B stated the baby gate was down for meals a few hours a day. RN-B stated there was no signed order or plan for staff to follow the use of the restraint. RN-B indicated she was unaware of other interventions tried to keep R1 safe besides the baby gait. RN-B indicated she was not aware of changes in R1's behavior and mood, or incidents involving other resident's, but stated sometimes R1 would cry or have loud vocalizations if unhappy. On April 6, 2023, at 2:45 p.m. ULP-E stated R1 had gone towards the exit doors but was easily redirected. ULP-E stated if staff were busy R1 was in his room with the baby gait up for up to six hours during a seven-hour shift. ULP-E stated if the baby gate was down R1 came out of his room to be with staff and other residents and indicated R1 liked to be around others. ULP-E stated other residents had used foul language towards R1 and had threatened to hurt him. ULP-E indicated in the past few months R1 had become more resistive with cares, toileting, refused to stand,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28686	A. BUILDING: _____ B. WING _____	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 22 refused to walk and scooted on his bottom instead, and had decreased intake. ULP-E indicated R1 had more rocking motions which was what he did when he was sad or upset. On April 10, 2023, at 4:32 p.m. LALD-C stated R1 liked to be around others but required constant supervision. LALD-C stated R1 was always into things like nick knacks, fans, touching outlets, putting things in his mouth, and would go towards the facility exit doors. LALD-C stated the exit doors had an alarm that would chime if anyone would come or go from the facility, but indicated it was turned off unless R1 was out of his room. LALD-C stated they did not have enough staff to provide one to one supervision for R1. LALD-C stated she knew the baby gate was a restraint and had tried to get a physician's order to use the baby gate, but the resident's provider refused to sign it because it would "restrict R1's rights". LALD-C stated R1's safety was more important, and they continued to use the baby gate. LALD-C stated R1 had been more stubborn lately and refused to walk. LALD-C stated since R1 eloped from the facility they had not implemented any other interventions to keep R1 safe. LALD-C stated she was unaware of any other options to keep R1 safe to be able to remove the baby gate. LALD-C stated there were no incident reports of resident's being physically or verbally aggressive toward R1 because the other residents didn't make contact with the resident, they only kicked at him. LALD-C stated they had no record of R1's weights being done since admission, because they did not have a scale R1 could use. LALD-C indicated R1's weights were done at the clinic but they had no record of them. A facility policy and procedure titled "Service Plan" dated December 1, 2016, indicated an	02310		

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02310	Continued From page 23 individualized service plan was implemented for all residents based on resident assessed needs. A facility policy and procedure titled "Staffing, Direct Care Staffing Plan, and Daily Schedule" dated August 1, 2021, indicated one or more persons would be available 24 hours per day seven days per week who are to respond to residents' health and safety needs. The staffing plan would provide sufficient staff to meet the needs of the resident's 24 hours a day. Each resident's needs were identified in the service plan, and acuity of the resident was based on the resident's most recent assessment. The policy indicated the staffing plan would be reviewed and revised a minimum of two times per year. A policy titled "Resident Records" dated August 1, 2021, indicated staff would document health information and services provided in the resident record. A policy and procedure for restraints was requested, none was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Two Days (2) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by:	02360		

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02360	Continued From page 24 Based on interview and document review, the facility failed to ensure one of one of one residents reviewed, (R1) was free from maltreatment. R1 was abused. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	